Report to the Legislature

Status of Implementation of the August 2002 JLARC Recommendations Regarding Children's Mental Health

RCW 71.36.050(1)

June 1, 2004

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EXECUTIVE SUMMARY

In 2002, the Joint Legislative Audit and Review Committee (JLARC) produced a study of the public mental health system for children and made recommendations for improvements to services and system performance, including the need for performance and client outcome measures. The following year the Washington State Legislature passed 2SHB 1784 (Chapter 281, Laws of 2003), supporting the recommendations made in the JLARC study.

This report fulfills the Department of Social and Health Services (DSHS) statutory requirement (RCW 71.36.050) to submit an initial implementation status report to the Governor and appropriate fiscal and policy committees of the legislature by June 1, 2004. The report provides preliminary details of tasks and activities undertaken by the department, with the assistance of the Office of the Superintendent of Public Instruction (OSPI) to implement the statutory requirements of RCW 71.35.040 to implement four of the JLARC Children's Mental Health Study recommendations.

1. Identify cross-agency business operation issues that limit ability to meet statutory intent to coordinate existing categorical children's mental health programs and funding.
2. Collect reliable mental health cost, service, and outcome data specific to children. This information should be used to identify best practices and costs of services.
3. Revise the Early Periodic Screening Diagnosis and Treatment plan to reflect current mental health system structure.
4. DSHS and OSPI should jointly identify school districts where mental health and education systems coordinate services and resources to provide public mental health care for children.

INTRODUCTION AND BACKGROUND

In 2001, the Washington State Legislature directed the Joint Legislative Audit and Review Committee (JLARC) to conduct a comprehensive children's mental health study. The purpose of the study was to review whether legislative intent was fulfilled regarding the coordination of children's mental health planning and services and the implementation of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. In addition, the study reviewed whether appropriate direction was available to the department in carrying out policy and management responsibilities based upon the 1991 children's mental health coordination statute.

JLARC produced its final report on the Children's Mental Health Study in August 2002. The report made five recommendations which were directed at streamlining and better integrating programs and services and increasing the systematic collection, analysis, and reporting of children's mental health service outcomes and costs. The Department of Social and Health Services (DSHS) concurred/partially concurred with the recommendations and the Mental Health Division (MHD) focused efforts on implementation.

The 2003 Legislature passed, and the Governor signed 2SHB 1784 (Chapter 281, Laws of 2003) supporting recommendations made in JLARC's 2002 study of the public mental health system for children. The legislation added two new sections to Chapter 71.36 RCW, coordination of children's mental health services. The new sections read as follows:

> RCW 71.36.040 – Issue identification, data collection, plan revision – coordination with other state agencies
>
> ***"****(1) The legislature supports recommendations made in the August 2002 study of the public mental health system for children conducted by the joint legislative audit and review committee.*
>
> *(2) The department shall, within available funds:*
> - *(a) Identify internal business operation issues that limit the agency's ability to meet legislative intent to coordinate existing categorical children's mental health programs and funding;*
> - *(b) Collect reliable mental health cost, service, and outcome data specific to children. This information must be used to identify best practices and methods of improving fiscal management;*
> - *(c) Revise the early periodic screening diagnosis and treatment plan to reflect the mental health system structure in place on July 27, 2003, and thereafter revise the plan as necessary to conform to subsequent changes in the structure.*

(3) The department and the office of the superintendent of public instruction shall jointly identify school districts where mental health and education systems coordinate services and resources to provide public mental health care for children. The department and the office of the superintendent of public instruction shall work together to share information about these approaches with other school districts, regional support networks, and state agencies."

RCW 71.36.050 – Report on implementation status

(1) In addition to any follow-up requirements recommended by the joint legislative audit and review committee, the department of social and health services shall submit a report to the governor and the legislature on the status of the implementation of the recommendations provided in RCW 71.36.040(2) (a) through (c) and, in coordination with the office of the superintendent of public instruction,on RCW 71.36.040(3). An initial implementation status report must be submitted to the governor and appropriate policy and fiscal committees of the legislature by June 1, 2004. A final report shall be provided no later than June 1, 2006.

STATUS OF IMPLEMENTATION EFFORTS

JLARC Recommendation 1 [RCW 71.36.040(1)(a)]

Identification of cross-agency business operation issues

Identify internal business operation issues that limit the agency's ability to meet legislative intent to coordinate existing categorical children's mental health programs and funding;

A number of initiatives have been undertaken towards improving cross systems collaboration within the department and between state agencies:

- Select Committee on Adolescents in Need of Long-Term Placement
- Treatment Foster Care Taskforce
- MHD/JRA development of cross systems protocols and transition agreements
- MHD/CA development of cross-system service delivery protocols
- DSHS Children's Mental Health Services Workgroup

Of significance is the establishment of a taskforce to study the highest need youth served by multiple systems within the department. This taskforce, known as the Select Committee on Adolescents in Need of Long Term Placement, was made up of community leaders and advocates, as well as DSHS administrators. The Committee published its final report in December 2002 making recommendations for improving the services and outcomes for youth with the highest need.

Acting on these recommendations, the DSHS Children's Administration (CA) formed the Treatment Foster Care Taskforce. This taskforce met during 2003 to review the foster

care system. It made recommendations of the type of foster care and treatment most likely to be effective and beneficial with high need youth in the foster care system. The final report is in draft form.

MHD and the Juvenile Rehabilitation Administration (JRA) worked together to develop cross systems protocols and transition agreements between each of the Regional Support Networks (RSN) within the public mental health system and each of the corresponding JRA regions. These agreements, completed in 2003, facilitate a smooth transition from JRA facilities to the community for youth who have mental health diagnoses.
MHD included in its 2001-2003 contract with the RSNs, a requirement that each RSN develop cross-system service delivery protocols for the coordination and integration of services with each of the DSHS CA Regions. Protocols were completed in October 2003 and presented at a December 2003 joint meeting of the RSN Administrators and CA Regional Administrators attended by the Assistant Secretaries of the Health and Rehabilitative Services Administration (HRSA), CA and JRA. The 2003-2005 RSN contracts with the MHD include a requirement that the RSN implement these protocols. In addition, a Dispute Resolution Agreement between MHD and CA was finalized after meetings which included input from the RSNs, CA regions and DSHS headquarters staff.

The MHD 2003-2005 contract with the RSNs includes a requirement for the RSNs to use treatment interventions that are research-based and shown to be effective in achieving positive outcomes when providing mental health services to children and youth. This requirement is the result of a recommendation of the Select Committee on Adolescents in Need of Long Term Placement.

In October 2003, the MHD received a Federal Substance Abuse and Mental Health Services Administration (SAMHSA) planning grant for the development of the use of evidence based practices. Efforts to identify and plan for the implementation of evidence based practices are underway with a workgroup consisting of service systems stakeholders.

The impetus to improve children and youth's mental health services in DSHS culminated in the creation of the DSHS Children's Mental Health Services Workgroup by the Assistant Secretaries of CA, JRA and HRSA in February 2004. This 30 member workgroup includes DSHS staff, providers, partners, parents, and stakeholders across each of the three systems. Tribes are also represented on the workgroup. The workgroup operates under a Vision Statement; Structure, Roles and Work Flow Chart; and Performance Agreement (Appendix 1-3). These documents ensure that workgroup members have a common understanding and agreement in relationship to their mission and desired outcomes.

Approximately 200 stakeholders have been invited to four meetings intended to solicit broader statewide input. A similar meeting with the Tribes took place in late May. Following these meetings, the workgroup is expected to draft recommendations for the assistant secretaries in the following three areas:

1) Definitions of and differentiation between mental illness, mental health, behavioral health, mental wellness and medical necessity, to promote clarity of scope and common understanding.

2) DSHS child/youth populations to be served; a set of services (service package) to be made available by DSHS, including and identifying best practices; and eligibility or level-of-need criteria for each service.

3) Key ideas and questions relevant to how the department might proceed to initiate the necessary changes to implement the system described in the recommendations.

In response to the recent Child and Family Services Review, the Children's Administration is developing a comprehensive reform plan which will address changes needed to the child welfare system. The changes needed to improve outcomes to children and families involve community partners and other DSHS administrations. The lack of appropriate and available mental health services for children was one of the areas identified as needing improvements. This major DSHS initiative to improve children's mental health services holds the promise of significant systems improvements.

JLARC Recommendation 2 [RCW 71.36.040(2)(b)]

Mental health cost, service and outcome data specific to children

Collect reliable mental health cost, service, and outcome data specific to children. This information must be used to identify best practices and methods of improving fiscal management;

MHD has undertaken the following implementation efforts:

- Data dictionary revision
- Performance indicators
- Outcomes Measurement System
- Mental Health Costs - development of a cost database

Data Dictionary Revision: The data dictionary, MHD's published manual of data elements and definitions, has been reviewed and revised in meetings with RSNs, providers, and consumers. Service definitions have been revised to increase reporting consistency and assure compliance with the Health Insurance Portability and Accountability Act. Data dictionary revisions are included in the RSN contract. MHD has developed a public web site that providers and clinicians can access (http://mswhite.com/datatrain/). The web site lists all data elements reported by providers, definitions, and codes. It provides training on rating scales, lists frequently asked questions, and directs additional questions to MHD for response.

Performance Indicators: MHD has incorporated 16 performance indicators into the annual Performance Indicator Report. The report has been published for two consecutive years and includes the following indicators:

1. Penetration rates for services by race/ethnicity, age, gender, and Medicaid eligibility
2. Utilization rate for services by race/ethnicity, age, gender, and priority population
3. Recipient perception of access
4. Recipient perception of quality/appropriateness of services
5. Recipient perception of active participation in decision making regarding treatment
6. Percentage of service recipients who are employed
7. Average annual cost per recipient served
8. Average annual cost per unit of service; cost per hour for community services
9. Percent of revenues spent on direct services
10. Percent of recipients who were homeless in the last 12 months by age and priority population
11. Percent of children who live in "family-like" settings
12. Percent of children and adolescents receiving services in natural settings outside of a clinician's office
13. Percent of recipients who are maintained in the community without a psychiatric hospitalization during the last 12 months
14. Percent of recipients who receive services by both MHD and the Division of Alcohol and Substance Abuse (DASA) in the previous 12 months
15. Percent of consumers who access physical healthcare
16. Percent of service recipients living in stable environments

Outcomes Measurement System: MHD has implemented a statewide outcome system for children and families served in the mental health system. The outcome system measures children at various points during treatment on the following variables: functioning, school performance, legal problems, living situation, quality of life and social interactions. The system has been piloted in selected agencies. State-wide implementation is anticipated to be complete in July 2004.

Mental Health Costs: MHD developed a cost database that estimates costs for each category of mental health service delivered. The system is currently being modified to estimate costs for children's services alone.

JLARC Recommendation 3 [RCW 71.36.040(2)(c)]

EPSDT plan revision

Revise the early periodic screening diagnosis and treatment plan to reflect the mental health system structure in place on July 27, 2003 and thereafter revise the plan as necessary to conform to subsequent changes in the structure.

In December 2002, MHD and the Medical Assistance Administration (MAA) updated the EPSDT plan in response to this JLARC recommendation. The updated plan is included in all 14 of the 2003-2005 RSN contracts with the MHD. A report on the EPSDT plan revision was submitted to the Washington State Legislature on December 1, 2003.

Since the EPSDT plan is an integral part of the contracts between the RSNs and the MHD, the use of the EPSDT continues to be an expectation of the public mental health system in cooperation with Healthy Options physicians contracted by MAA. The updated plan simplifies and clarifies the use of the EPSDT. The plan will be revised as necessary to conform to subsequent changes in the mental health system.

The department convened an EPSDT Improvement Team to address ongoing issue with the use of EPSDT plans. EPSDT Improvement Team meetings provide the opportunity for input, discussion of issues and sharing of information, and coordination by representatives of the MAA Healthy Option Plans, the Washington State Department of Health (DOH), DSHS CA, MAA, MHD, other cross systems partners and the Centers for Medicare & Medicaid Services (CMS).

JLARC Recommendation 4 [RCW 71.36.040 (3)]

Coordination with OSPI to identify and disseminate models of best practices

The department and the office of the superintendent of public instruction shall jointly identify school districts where mental health and education systems coordinate services and resources to provide public mental health care of children. The department and the office of the superintendent of public instruction shall work together to share information about these approaches with other school districts, regional support networks, and state agencies.

Collaboration between DSHS and the Office of the Superintendent of Public Instruction (OSPI) can be traced back to the Seriously Behaviorally Disturbed (SBD) Taskforce initiated in Fall 1997 by the Secretary of DSHS and Superintendent of Public Instruction. The taskforce report was published in June 1999. An overarching interagency agreement between DSHS and OSPI was developed and signed in 2001. In addition, a program agreement between OSPI Special Education Operations and DSHS MHD was signed in 2003.

As a result of the interagency agreement, and in response to the JLARC request, joint meetings between MHD and OSPI staff began in 2002, and continue on a bimonthly basis. One of the activities under the program agreement was the distribution of the MHD Directory of RSNs and public mental health system providers within each RSN to

local public school districts at the Special Education Administrators Summer Institute in August 2003.

MHD and OSPI staff initiated a process during the Fall 2003 to identify key components of exemplary practices in coordination between local school districts and public mental health agencies. The development of the indicators for promising practices included consultation with the University of California, Los Angeles Center for Mental Health in Schools and a review of the Behavioral and Emotional Assessment and Curriculum for the Ongoing Needs of Students (BEACONS) Model Demonstration Project. Researchers also reviewed and consulted with the Seattle Social Development Project, the Coalition for Community Schools (Institute for Educational Leadership), Readiness to Learn, Safe and Healthy Schools, and the Systems of Care projects in King and Clark Counties.

Research identified four components of successful programs:

1. Family and community engagement, together with school efforts, promotes a school climate that is safe, supportive and respectful. It provides an array of mental heath services and educational opportunities to meet the mental health and academic needs of the student and his/her family.

2. The school and mental health providers coordinate training for school staff, communities, and families.
3. Mental health providers and school staff work together to provide an integrated and comprehensive array of mental health services and educational opportunities.

4. The mental health providers and schools coordinate data collection and analysis.

A survey was developed to send to school districts, the RSNs, and public mental health agencies (Appendix 4). The survey was conducted in November and December of 2003. A preliminary analysis identified 22 programs warranting further analysis to determine if they meet the criteria for selection as a promising practice. In order to refine the selection process, a rubric was developed which identified the indicators and evidence a program must meet in order to be selected as a promising practice (Appendix 5).

Next steps include:

- Use the rubric to conduct a review of the 22 identified promising programs.
- Obtain additional information through documentation review, site visits and targeted surveys.
- Develop and implement a dissemination plan to include:
    - Specific identification of promising practices and information on each agency's web site;
    - Presentations of promising practices at each agency's conferences, training institutes and meetings and;
    - Mechanisms for continued dialogue and coordination between MHD and OSPI regarding development and implementation of these promising practices.

CONCLUSION

Following completion of the JLARC Children's Mental Health Study, the department initiated and continued a number of projects and initiatives focused on identifying and making improvements to the children's public mental health system. The department has made considerable progress towards implementation of JLARC's recommendations and remains committed to ensuring that the mental health needs of Washington State's children are met within a coordinated and comprehensive framework. This report provides a status update on the department's progress. A final report will be provided as required by statute by June 1, 2006.

APPENDICES

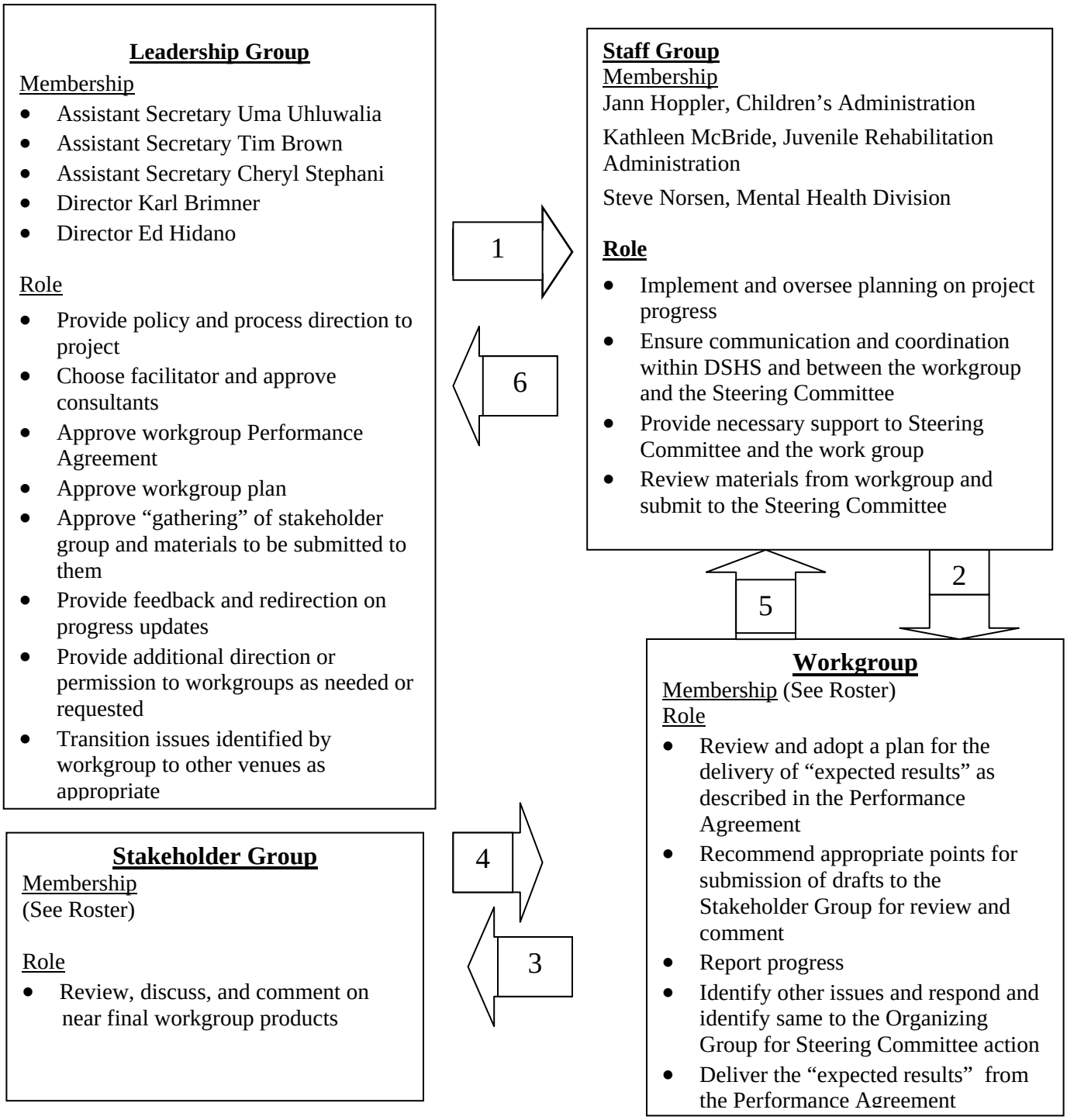
Appendix 1: Vision Statement for Children's Mental Health

Vision Statement for Children's Mental Health

We, the Assistant Secretaries for Children's, Health and Rehabilitation Services (Mental Health), and Juvenile Rehabilitation Administrations within DSHS envision a different, systemic, culturally competent, coordinated approach where child and family needs drive an effective mental health service delivery system. In this DSHS system:

- There are common definitions of mental health, behavioral health, mental illness and mental wellness.
- Services and supports are targeted to achieve identified outcomes based on risk and protective factors in existence for each child and family.
- Services and supports are based on evidenced-based and promising practices with a clearly identified scope of practice and outcomes, in order to be as effective as possible.
- Service providers are well trained in these practices.
- The department and its contractors use similar treatment approaches so children and families don't need to start over when they move through the system.
- There will be better use of resources which <u>may</u> include service and system re-design.

Appendix 2: Structure, Roles, and Work Flow Children's MH Work Group



Appendix 3: Performance Agreement DSHS Children's Mental Health Services Work Group

What We Are Doing

- DSHS is reviewing its multi-administration--Mental Health Division (MHD), Children's Administration (CA) and Juvenile Rehabilitation Administration (JRA), services to children who present with mental health needs.
- DSHS is seeking a redefined, systemic, culturally competent, coordinated, and evidenced-based mental health delivery system for children.
- DSHS is seeking improved outcomes, more effective processes, and efficiencies.
- DSHS is seeking full stakeholder participation in the review and the recommendations that come out of the review.

Results Expected

1. Comment and constructive recommendations related to the draft vision, guiding principles, outcomes and work plan.

2. Recommendations on definitions of and differentiation between mental illness, mental health, behavioral health, mental wellness, medical necessity, etc. to promote clarity of scope and common understanding.
   - Ensure that terms used by this group mean the same thing to all members. These may become definitions standardized across DSHS.

3. Recommendations in the following areas within current resources; within the sum of current mental health expenditures from the three administrations.
   a) DSHS populations to be served (0-17 years old, including transition to adulthood for those entering service before 18).
      - Incorporate the defined groups from number 2 above as well as others as needed.
      - Consider populations including diagnostic groups, ages, prevention & early intervention, low & moderate need, domestic violence, trauma settings and outreach.
      - Consider different developmental needs of various age groups.
      - Address the populations that may currently be marginally or unclearly connected to DSHS (non-adjudicated sex offenders, eating disorders, fire setters, autism).
   b) A set of services (service package) to be made available by DSHS to 0-17 year old children. Include and identify best/promising practices.
      - Recommend and define services to be included in the DSHS service package.
      - Recommend evidence based practices (EBP), research based, and promising practices (PPs) for inclusion in the DSHS service package.

- Recommend DSHS adoption of a currently available set of criteria for inclusion of new EBPs or PPs.

c) Eligibility or level-of-need criteria for each service.

4. Develop key ideas and questions relevant to how the Department might proceed from here to initiate the necessary changes to implement the system you've described.

Guidelines

1. Think kid and family needs, not bureaucratic-structure needs.
2. Think "DSHS" and not CA, MHD, and JRA. This exercise is starting with the department's response in mind, not specific administrations within the department.
3. See Structure, Roles, and Information Flow sheet for project structural framework.
4. Remember Secretary Braddock's statement last June encouraging us all to develop a more "humble" view of the DSHS role while recognizing the power of family members, neighbors, community systems, and informal support networks.
5. Stay on assignment, "Results Expected".
6. Use DSHS provided materials on evidence based, research based, or promising services.
7. Use a "parking lot" to save important but tangential issues that should be addressed later or returned to DSHS for another venue.

Accountability

1. Review and adopt the work plan for the group from the Leadership Group after your first meeting reflecting steps to delivering the "Results Expected" and time lines. The time line will reflect delivery of the "Results Expected" in June, '04.
2. Submit updates to the Leadership Group after each meeting and upon significant movement toward the "Results Expected" or at least monthly.
   a) Updates shall:
      - Be simple and brief
      - Be specifically related to the "Results Expected"
      - Estimate a completion date
   b) Updates may:
      - Offer recommendations for new or different expected results
      - Request information, support, guidance, or other assistance from the Leadership Group.
      - "Parking lot" items that warrant work at another time or place

Process Notes

- DSHS will provide a facilitator.
- DSHS will contract for expert consultation.
- DSHS will provide staff support and cover the costs of renting rooms etc.

- DSHS will consider requests for per diem and travel costs from workgroup members. Any such requests must be approved in writing in advance of the expenditure.
- See the "Structure, Roles, and Work Flow" sheet for additional information.

Membership

- The workgroup is not authorized to add membership in an effort to maintain consistency and continuity in our tight time frames.
- Workgroup members will not send substitutes to meetings they can't attend, again in an effort to maintain consistency and continuity.

Future Possible Work

Review the results of this workgroup and consider identifying additional populations, services, or eligibility criteria to be included if resources were increased.

Appendix 4: Coordinated School/Mental Health Services

School District	School representative and Contact information	Mental Health Provider	Mental Health representative and contact information	Program Name (if applicable)	Brief description of how services are coordinated, positive outcomes that have resulted, and the infrastructure that is in place to support those outcomes.

Appendix 5: Promising Practices

PROMISING PRACTICES
[DRAFT]

I. Practice: Family and community engagement, together with school efforts, promotes a school climate that is safe, supportive and respectful. It provides an array of mental health services and educational opportunities to meet the mental health and academic needs of the student and his/her family.						
Evidence: (Information Dissemination) Indicator (1): *Evidence of outreach to families with mental health needs.* Indicator (2): *Connection to appropriate and local resources and advocacy for families.*	Informational Materials/Documents	Public Meetings	Environment/Culture	Culturally/Linguistically Competent Staff	List of Community Partners	Interagency Agreement/ MOU

Indicator (3): *Individual voices are encouraged and valued as equal partners in program development and improvement.* Indicator (4): *Services are provided in a safe and healthy environment.*						

II. Practice: The school and mental health providers coordinate training for staff, communities, and families.						
Evidence: (Training) Indicator (1): *Training opportunities are evident.*	Public Announcements	Knowledgeable Trainers (credentials/experience)	Environment/Culture	Culturally/Linguistically Competent Staff	Training Materials	Alternative Training Materials and Format

Indicator (2): *Training provided is accessible to all individuals* • *Time* • *Place* • *Individuals with disabilities* • *Joint training* • *LEP sensitive* Indicator (3): *Trainers have proper knowledge base* Indicator (4): *Ongoing training to provide continued learning*						

III. Practice: Mental health providers and school staff work together to provide an integrated and comprehensive array of mental health services and educational opportunities.					
Evidence: (Integrated Services) Indicator (1): *District wide programs.* Indicator (2): *Positive behavior supports.* Indicator (3): *Mental health services are provided on school grounds.* Indictor (4*): Mental health service access extends beyond the school day.*	Stated Student Outcomes	School Schedule (time and place)	Community/School Teams	Planning/Implementing Meeting Notes	Interagency Agreement/MOU

IV. Practice: The mental health providers and schools coordinate data collection and analysis.			
Evidence: (Data) Indicator (1): *Agreement to share data.* Indicator (2): *Data used to establish benchmarks.* Indicator (3): *Ongoing data collection is used to identify areas for program improvement.* Indicator (4): *Data used to demonstrate positive outcomes.*	Stated Student/Family Outcomes	Data Collection System	Interagency Agreement/MOU